Rose Sher, Somatic Therapy

CLIENT INFORMATION

Last Name_____ First Name_____

Address_____

City_____ State_____ Zip_____

Home Phone_____ Work #_____ Cell #_____

Email_____ Occupation_____

Birthday_____ Ht_____ Wt_____Age_____

Referred By _____

Are you currently under medical care? If yes, please explain: _____

_____Doctor's Name _____

Please list any Surgeries, Accidents or Injuries: When?
(Use other side if necessary)

_____ _____

_____ _____

_____ _____

_____ _____

Have you ever had previous bodywork? What? _____

Are you currently doing any physical activity? Please explain: _____

_____

Reason for visit: _____

The Practitioner of Structural Integration does not treat, prescribe or diagnose an illness, disease or other physical or mental disorder. Structural Integration does not substitute for medical treatment or diagnosis when such attention is needed. Any suggestions made during my visit are only recommendations, not prescriptions.

PLEASE GIVE 24 HOURS NOTICE OF CANCELLATION OR FULL PAYMENT IS DUE.

Signature_____Date_____